

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28741**
Registrar's No. **4144**

FILED **SEP 11 1953**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 10 yrs		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION K.C. General Hosp. #1		e. STREET ADDRESS (If rural, give location) 4321 E. 10th Street	
3. NAME OF DECEASED a. (First) Jane b. (Middle) E c. (Last) McKay		4. DATE OF DEATH (Month) 8 (Day) 22 (Year) 53	
5. SEX Fe	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 5, 1870
9. AGE (In years last birthday) 83		10. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) South Wales
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		14. NAME OF HUSBAND OR WIFE John McKay	
13b. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -	
16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME John McKay, 4321 E. 10th St. KC. Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident ANTECEDENT CAUSES DUE TO (b) Hypertensive cardiac disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 443X	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug. 11 , 19 53 , to Aug 22 , 19 53 , that I last saw the deceased alive on Aug. 22, 19 53 , and that death occurred at 5:30 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE B.I. Burns (Degree or title) B.I. Burns, M.D.		23b. ADDRESS 24th and Cherry Streets	
23c. DATE SIGNED 8-23-53		24. LOCATION (City, town, or county) (State) Frankfort Kansas	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 23 53	24c. NAME OF CEMETERY OR CREMATORY Frankfort Cemetery	24d. LOCATION (City, town, or county) (State) Frankfort Kansas
DATE REC'D BY LOCAL REG. 8-23-53	REGISTRAR'S SIGNATURE Sheraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Stine MC Clure ADDRESS K.C. Mo.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. H. Allen*

Licensed Embalmer No. *14*

P. O. Address *R. M. Co.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.